

BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

VICKY BATY)	
Claimant)	
V.)	
)	Docket No. 1,060,444
FOOT LOCKER RETAIL, INC.)	
Respondent)	
AND)	
)	
AMERICAN CASUALTY COMPANY OF)	
READING, PA)	

ORDER

Claimant requested review of the September 8, 2014, Award by Administrative Law Judge (ALJ) Rebecca Sanders. The Board heard oral argument on January 6, 2015.

APPEARANCES

Jeff K. Cooper, of Topeka, Kansas, appeared for the claimant. Eric K. Kuhn, of Wichita, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The Board has considered the record and adopted the stipulations listed in the Award.

ISSUES

The ALJ found the primary issue is whether claimant's permanent impairment resulting from her work injury is confined to the left shoulder or includes the upper back and cervical spine. Dr. Hufford's opinion was found to be the most credible because it not only accounts for the left shoulder replacement, but also includes residual problems claimant has with her left shoulder. Claimant was awarded a 38 percent permanent impairment to the left shoulder. Respondent was ordered to provide claimant with a list of two physicians from which claimant was to select a pain management physician. The claimant was awarded 63.00 weeks of temporary total disability compensation at the rate of \$230.39 per week. Any unauthorized medical was ordered to be reimbursed to claimant up to \$500.00, less any previously reimbursed unauthorized medical. Respondent was ordered to pay all authorized medical expenses related to treatment of the claimant's injuries, subject to the

Kansas Workers Compensation Schedule of Medical Fees. All known medical expenses to date, totaling \$83,258.15, have been paid.

Claimant appeals, arguing she has a whole body impairment based upon myofascial pain syndrome affecting the neck and upper back. Claimant also argues her credible testimony, along with that of the medical experts evidences she is incapable of working at her former capacity. Therefore, she should receive a permanent partial general disability (work disability) award. Finally, claimant argues the greater weight of the credible evidence supports her assertion that she should receive future medical care.

Respondent argues the Award should be affirmed as claimant has not met her burden of proving injury beyond the left shoulder.

Issues on Appeal:

1. Is claimant limited to a functional impairment to the left shoulder, or should the neck and upper back be included in the award?
2. If claimant is entitled to a general body disability under K.S.A. 44-510e, what is the nature and extent of that disability?
3. Is claimant entitled to future medical treatment as a result of the work injury?¹

FINDINGS OF FACT

Claimant's job with respondent was as a MH-1 handler. This job required putting parts on an induction machine that goes around and takes merchandise down a chute to be packed and shipped to customers. This was a full-time position and paid \$9.55 an hour.

On July 18, 2011, claimant suffered injury to her left shoulder in the course of her employment with respondent. Claimant was working on an induction machine and tried to catch a part that was falling off the machine. As she reached out to catch the part her hand got caught in the turning machine and overextended, pulling her left arm back at the shoulder. Claimant testified she felt pain in the front and back of her left shoulder as her arm was being pulled behind her. Claimant reported the injury to her supervisor and was referred to the workers compensation physician assistant, Michael Beffa, on July 21, 2011. She was provided prednisone and Lortab and was referred for several sessions of physical

¹ The Award grants claimant future medical treatment upon application, but limits the medical treatment to claimant's shoulder. The future medical dispute centers around claimant's contention that she also injured her neck as the result of her work-related accident. Respondent, in its brief to the Board, requests the Award be affirmed, with no argument against future medical treatment for the shoulder. Should claimant's award be affirmed, and thus limited to the shoulder, the award of future medical treatment upon application for the shoulder will be affirmed.

therapy. The therapy provided only temporary relief. Claimant testified that about a week after the accident, she started having neck and mid-back pain.

Claimant was referred for treatment with board certified orthopedic surgeon Lowry Jones, Jr., M.D. Claimant first met with Dr. Jones on August 11, 2011, at the request of respondent's insurance company. She reported left shoulder pain which began on July 18, 2011, when she sustained the injury to the shoulder. Claimant testified she reported the neck and mid-back problems to Dr. Jones when she first saw him. However, the office notes from August 11, 2011, mention only the left shoulder. Claimant testified Dr. Jones never examined her neck.

An MRI taken earlier showed a horizontal tear of the supraspinatus tendon in the left shoulder. Dr. Jones' working diagnosis at the time was a partial thickness or high grade partial tear of the rotator cuff of the left shoulder. He wrote the mechanism for claimant's injury was from repetitive vocational duties of the left shoulder. Dr. Jones noted claimant had been in an immobilizer for two weeks which improved her pain, but left her unable to use her left arm.

Claimant continued to work for respondent on light duty at the time of this evaluation. Claimant's initial treatment after her accident included medication and eight sessions of physical therapy. The medication had an adverse effect on claimant and she stopped taking it. The physical therapy helped for about a day after the end of the sessions. Dr. Jones assessed claimant's pain as mild to moderate in intensity, dull and aching in character, relieved by rest and provoked by activity, without radiation.

Dr. Jones examined claimant and found her gait and station normal; right shoulder range of motion, alignment, stability, and muscle tone were normal; left shoulder alignment, stability, and muscle tone were abnormal. Claimant had significant pain and stiffness past 110 degrees of flexion and 100 degrees of abduction with range of motion; supraspinatus test with empty can test was painful, but not weak; mild TTP along the anterior and posterior aspect of the shoulder; no weakness of resisted external rotation at 90/90; no subacromial crepitation. Dr. Jones assessed rotator cuff tear of the left shoulder. The tear was longitudinal without detachment. Claimant also had a possible proximal bicep tendon pathology on mechanism of injury and MRI scan.

Dr. Jones planned to do a left shoulder arthroscopic rotator cuff repair and possible labrum debridement. Claimant was to wear an immobilizer as needed for pain, and needed to come out of it regularly to do motion exercises. A pulley was to be provided to be used regularly at home before surgery and claimant would return to work on light duty with no use of the left arm and no repetitive reaching, pushing or pulling with either arm. Dr. Jones felt claimant would be at maximum medical improvement three months post surgery.

On August 19, 2011, Dr. Jones performed a left shoulder arthroscopy with chondroplasty of the humeral head and glenoid including debridement of the inferior labrum; a decompressive acromioplasty and arthroscopic rotator cuff repair. During the procedure Dr. Jones found extensive wear of the articular surface of the glenoid with lesser changes of the humeral head, chronic wear changes with evidence of significant articular wear and probable chondrolysis of the inferior half of the glenoid. He was not able to retract the inferior labrum because it was not torn from the bone, but was elevated from chronic wear. The superior half of the glenoid had some articular cartilage and the humeral head had the articular flap changes that were debrided, primarily with grade 1 and grade 2 changes. The biceps tendon was normal and there was a type I SLAP lesion debrided. The rotator cuff had a definitive partial tear of the posterior aspect of the supraspinatus and the undersurface tear extended into what appeared to be full-thickness tear.

Claimant met with Dr. Jones again on August 29, 2011, at which time she continued to have pain in her left shoulder post surgery, which limited her activity. Claimant's sutures were taken out, she was given wound care instructions, a home exercise was reviewed and she was instructed to return in four weeks at which time therapy would be started.

Claimant returned to Dr. Jones on September 26, 2011. She continued to have pain in her left shoulder which limited her activity. Claimant reported her pain level being an 8 out of 10 at rest and a 9 with activity. She also reported being depressed and angry. Claimant's range of motion was 100 degrees with flexion, she had mild crepitation and had minimal swelling. Her strength was satisfactory, but limited on exam. Dr. Jones felt claimant was improving. The operative findings were discussed with claimant, and the plan was for claimant to begin formal physical therapy. Claimant was restricted from use of the left arm.

Claimant continued to have left shoulder pain at her November 7, 2011, visit with Dr. Jones. She reported the left shoulder pain was a 6 out of 10 at rest and a 7 with activity. This was an improvement from her previous levels, but claimant reported her pain was no better. Her range of motion was improved, but her pain was still limiting. Claimant was five weeks post surgery, and four weeks into physical therapy. Claimant's flexion was 160 degrees, but she had significant pain with all range of motion. There was mild crepitation, minimal swelling and limited strength. Dr. Jones opined that because claimant is not improving, she would likely need a total shoulder arthroplasty (replacement) once her rotator cuff healed. Claimant was instructed to continue with formal physical therapy and home exercises. Claimant was also to continue with the restriction of no use of the left arm.

Claimant returned to Dr. Jones on December 12, 2011. Her left shoulder pain level was a 4 out of 10 at rest and a 7 with activity. Claimant reported her range of motion was improved, but again complained her pain was no better. Because of her pain, claimant had a hard time increasing strength in her left arm and shoulder. Dr. Jones noted claimant had

chondrolysis of the glenoid lower 50% and opined that since claimant was not improving she would likely need total shoulder arthroplasty or tissue allograft to the glenoid. The risks of both procedures were discussed and claimant was urged to seek a second opinion with Dr. Satterlee, who has performed several soft tissue allograft procedures.

Dr. Jones opined, within a reasonable degree of medical certainty, the primary source of claimant's pain was the chondrolysis of her glenoid. The chondrolysis in his opinion was directly related to her injury. Although claimant had degenerative changes present of the inferior glenoid, he believed those were secondary from loss of the glenoid articular cartilage. She had multiple loose articular fragments consistent with traumatic injury. Dr. Jones believed any surgical procedure recommended would be directly related to her injury July 18, 2011.

Dr. Jones ordered formal physical therapy and a home exercise plan. He assigned restrictions of no repetitive use of the left arm, no reaching, pushing, or pulling with the left arm and claimant was to grip and hold only small objects with the left hand.

Claimant returned to Dr. Jones on June 4, 2012, for a recheck of the left shoulder. Dr. Jones was not aware if claimant saw Dr. Satterlee for the second opinion recommended at the December 12, 2011, visit. However, according to respondent's counsel, claimant saw Dr. Satterlee on March 16, 2012.

Claimant continued to have pain in her left shoulder. Her pain level was a 9 out of 10 both at rest and with activity. Dr. Jones noted claimant had a very arthritic left shoulder joint and she needed a total shoulder replacement. Claimant also understood she would need pain management following surgery. Dr. Jones examined claimant and found left shoulder pain, left shoulder degenerative joint disease and addiction to narcotic pain medication. His plan was to replace claimant's shoulder and get her into pain management. Restrictions were to avoid any repetitive lifting, pushing, or pulling with the left upper extremity.

Dr. Jones performed a left total shoulder replacement on June 12, 2012. Claimant tolerated the procedure well. Claimant had a post left shoulder replacement surgery visit on June 25, 2012. She was doing fair post surgery. She had pain level of 4 out of 10 at rest and a 9 with activity. Dr. Jones noted claimant's pain was moderate and she had been working with physical therapy on her range of motion. Claimant's surgical wound was healing satisfactorily. Radiographs of the shoulder showed satisfactory placement and maintenance of position of the prosthesis. Dr. Jones instructed claimant to continue with physical therapy, to wear an immobilizer full-time when not in therapy and to not use the left arm.

Claimant was next examined by Dr. Jones on July 23, 2012, five weeks post left total shoulder replacement. Her pain level was a 5 out of 10 at rest and a 9 with activity. Claimant was doing fair post surgery and the goal was to get claimant in pain

management, work her out of her immobilizer and to get her off pain medication. Claimant was again instructed to not use her left arm.

Claimant next saw Dr. Jones on September 10, 2012, twelve weeks post left total shoulder replacement. She had a pain level of 5 out of 10 at rest and 8 with activity. Dr. Jones wrote claimant's problem continued to be pain in her left shoulder so bad that she had been taking 8 pain tablets a day. Dr. Jones wrote claimant was doing fair after shoulder replacement, and that pain control was claimant's primary issue. He opined she may need pain management to get her off pain medication. He expressed concern that if claimant could not get her pain controlled, hospitalization may be necessary. Claimant's passive range of motion, clinical exam and x-rays were good. He wrote he didn't think there would be a significant improvement in claimant's activity until her pain medication is discontinued. Dr. Jones recommended claimant continue with therapy and recommended no reaching, pushing or pulling with the left shoulder.

On October 15, 2012, seventeen weeks post left total shoulder replacement, claimant continued to complain of pain, but her function was improved. Her pain level was a 7 out of 10 at rest and with activity. She was still having trouble lifting. Her active motion was fair and her passive motion remained very good. Dr. Jones recommended another four weeks of therapy which would be discontinued if there was no benefit. Dr. Jones recommended no reaching, pushing or pulling with the left shoulder. Claimant was in pain management with Dr. Hu.

On November 19, 2012, twenty-two weeks post left total shoulder replacement, Dr. Jones found claimant was doing well with her passive and active range of motion and her x-rays looked good. She had pain level of 6 out of 10 at rest and with activity. She complained of overall anterior discomfort which remained unchanged since prior to surgery. Dr. Jones recommended claimant perform no repetitive reaching, pushing or pulling with the left upper extremity above shoulder level and limit lifting to 20 pounds. Claimant was found to be at maximum medical improvement.

Claimant's employment was terminated November 20, 2012, as she was unable to perform her job duties under the permanent restrictions of Dr. Jones. Claimant has not worked since her employment was terminated. She does not feel she is capable of working despite drawing unemployment for a short period. Claimant testified that most of the work she performed over the years were factory jobs and she doesn't feel she could return to that kind of work. She is not able to perform any kind of telemarketing job if it involves typing, as claimant is not a good typist. She is also unable to do any lifting. Claimant looked for work through Workforce, a temporary employment agency, and looked for anything she felt she was physically able to do. She applied, but got no interviews. She has applied for Social Security disability.

On November 29, 2012, Dr. Jones provided a Disability Rating Report indicating claimant sustained an injury to the left shoulder and was diagnosed with left shoulder high

grade partial rotator cuff tear with impingement and significant chondrolysis of the humeral head and glenoid on July 18, 2011. He found claimant to have a 30 percent permanent partial impairment to the left shoulder pursuant to the *AMA Guides*, 4th edition² He did not feel that any of claimant's impairment rating was attributable to any preexisting conditions. Dr. Jones attributed all of claimant's treatment and the subsequent impairment rating to the injuries sustained in the course of claimant's employment. Claimant's progress was limited due to her young age and the prosthesis.

Claimant returned to Dr. Jones on July 8, 2013, at the request of the insurance company. She continued to have left shoulder pain. Her level of pain was 5 out of 10 at rest and an 8 with activity. Claimant reported the pain in her shoulder was exactly the same. Claimant continued with her pain medication and has not returned to work. A neurologic exam of both upper extremities was normal and motor function was good. Her strength didn't appear to be quite as good at his last visit, but there was no need for additional treatment of the left shoulder. Claimant was again found to be at maximum medical improvement and told to continue to limit her activity due to her young age³ and to avoid repetitive significant lifting, pushing or pulling with the left upper extremity and to avoid lifting over 20 pounds. These restrictions were considered permanent. Dr. Jones testified that claimant will likely need future medical care related to her left shoulder.

Dr. Jones testified that in all of his chart notes there is no reference to claimant complaining of neck pain. Dr. Jones testified he did not believe claimant suffered a work-related injury to her neck from the original injury. In his opinion, after treating claimant for two years, her injury was isolated to the left shoulder. He could not recall a time when claimant complained of neck or upper back pain. He did evaluate claimant's neck as it can not be isolated from the shoulder, but he did not write down anything about the neck because claimant had no complaints to the neck and there were no positive findings. Dr. Jones asked claimant if she had pain anywhere else and he performed a neurologic exam that was normal. If claimant had complained of the neck, he would have included it in the record.

Claimant met with Pedro Murati, M.D., on May 22, 2012, for an examination at the request of her attorney. She had complaints of neck pain, left shoulder pain, difficulty lifting overhead with the left shoulder, and left hand numbness and tingling which radiated from her shoulder to her hand. Claimant reported to Dr. Murati that her neck pain began one week after the accident and that she reported this to Dr. Jones. Claimant denied any prior significant injuries to the left shoulder or neck. She did report a prior injury to her collarbone in a car accident and she suffered a broken right wrist in junior high.

² American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.). All references are to the 4th edition unless otherwise noted.

³ Claimant was 48 years old at this time.

Claimant described her work duties for respondent as sorting and inducting, which involved repetitive bending, lifting, stooping, pushing, pulling, standing, grasping, writing, climbing, kneeling and reaching. Claimant reported she would lift 50-70 pounds daily.

Dr. Murati noted claimant previously met with Dr. Satterlee on March 5, 2012⁴, and reported her neck bothers her a little sometimes, but this was chronic and not related and the only thing she hurt was her left shoulder. Dr. Murati noted Dr. Satterlee discussed claimant's surgical and medical options available to her, given her age. Dr. Murati agreed with the opinion of Dr. Jones that the prevailing cause of claimant's need for surgery is her injury at work. Dr. Murati also felt, whether claimant had surgery or not, she should consider pain management.

Dr. Murati examined claimant and found claimant's MSRs for the upper extremities to be equal. Sensory touch to pinprick revealed a decrease in sensation along the right second digit and along the first and third digits on the left, muscle strength testing for the upper extremities revealed to be 4/5 bilaterally and 4/5 left shoulder secondary to pain. There was a positive left carpal compression examination within 10 seconds and negative on the right. Examination of the shoulder revealed a negative rotator cuff on the left. There was a positive Hawkins and O'Brien's examination. There was severe glenohumeral crepitus of the left shoulder and limited range of motion in all planes of the left shoulder. Examination of the neck revealed a negative Spurling's. There was missing right lateral flexion. There were trigger points of the left shoulder girdle extending into the cervical and thoracic paraspinals.

Dr. Murati diagnosed status post left shoulder arthroscopy with chondroplasty of the humeral head and glenoid including debridement of the inferior labrum, decompressive acromioplasty, arthroscopic rotator cuff repair; left carpal tunnel syndrome; and myofascial pain syndrome of the left shoulder girdle extending into cervical and thoracic paraspinals. Dr. Murati opined that within all reasonable medical probability the diagnoses are a direct result from the July 18, 2011, work injury. He recommended claimant have a left shoulder replacement; bilateral upper extremity NCS/EMG to evaluate and/or document any nerve entrapments performed and, based on the results, appropriate physical therapy, splinting, anti-inflammatory and pain medications as needed and then cortisone injections. If conservative treatment fails, a surgical evaluation would be recommended. For the myofascial pain syndrome, appropriate physical therapy with pain release techniques, cortisone trigger point injections and anti-inflammatory medications and pain medications as needed as well as Zanaflex to reduce muscle spasms.

Dr. Murati recommended temporary restrictions based on an eight hour workday of no climbing stairs, no crawling, no heavy grasping greater than 40 kg with the left, no above chest level work with the left, no work more than 18 inches from the body with the

⁴ There are at least two other instances in the record indicating claimant's visit with Dr. Satterlee was on March 16, 2012.

left, avoid awkward positions of the neck, avoid trunk twist, and only occasional repetitive grasping or grabbing or frequent use of hand controls with the left.

Dr. Murati opined claimant's injury at work was the prevailing factor for the left shoulder and neck pain. He wrote claimant's injuries at work have restricted her hobbies, but do not pose a reasonable risk for other injuries. He noted claimant denied any significant preexisting conditions to the injured body parts. Therefore, he found under all reasonable medical certainty the prevailing factor in the development of claimant's current impressions is the work accident of July 18, 2011.

Claimant met with Dr. Murati for another examination on March 12, 2013. This evaluation was to include an impairment rating. Claimant had complaints of neck pain, left shoulder pain, difficulty lifting overhead with the left shoulder, left hand numbness and tingling which radiated from shoulder to hand and upper back pain. Claimant reported her employment had been terminated and she was not working.

Dr. Murati's examination findings included: some dysesthesias in the left axillary distribution; weakness in the left shoulder due to pain; positive rotator cuff and positive Hawkins on the left; no crepitus; severe decreased range of motion; flexion at 110 degrees with normal at 180 degrees; abduction at 100 degrees with normal at 180 degrees; internal rotation was 10 degrees and should be closer to 60; external rotation was 40 degrees and should be greater than 69; adduction was 10 degrees and should be closer to 30; claimant had a negative Spurling, but had limited range of motion in the neck with trigger points in the left shoulder girdle extending to the cervical and thoracic paraspinals. Dr. Murati indicated triggers points were an objective sign of a problem and in claimant's case it was a sign of a poor result from shoulder surgery.

Dr. Murati assigned the following impairment rating: for dysesthesias of the left axillary distribution, 3 percent to left upper extremity; for loss of range of motion of the left shoulder, 16 percent to left upper extremity and for complete shoulder replacement, 30 percent to left upper extremity. The upper extremity impairments combine for a 43 impairment to the left upper extremity, which converts to a 26 percent whole person impairment. For the myofascial pain syndrome affecting the cervical paraspinals, 5 percent to the whole person. For the myofascial pain syndrome affecting the thoracic paraspinals, 5 percent to the whole person. The whole person impairments combine for a 34 percent whole person impairment. His ratings were pursuant to the *AMA Guides*, 4th edition.

Dr. Murati assigned permanent restrictions of no climbing ladders, no crawling, no work more than 18 inches from the body with the left, no above chest level work with the left, no lifting, carrying, pushing or pulling more than 20 pounds, 20 pounds occasionally and 10 pounds frequently and avoid awkward positions of the neck and avoid truck twist.

Dr. Murati again found under all reasonable medical certainty the prevailing factor in the development of claimant's current conditions is the work accident of July 18, 2011.

This opinion was based on the fact claimant sustained an accident at work that resulted in shoulder, neck and back pain, that claimant is young, that she is a non-smoker, and she had no preexisting injuries related to her recurrent diagnosis.

On April 10, 2013, Dr. Murati wrote an addendum letter to his May 22, 2012, report to claimant's counsel confirming his review of x-rays of claimant's shoulder on CD and confirming the diagnosis of claimant's condition during his May 22, 2012, evaluation.

On July 31, 2013, Dr. Murati wrote another letter to claimant's counsel confirming his diagnosis of claimant's condition at his March 12, 2013, examination of claimant and stating that, in his professional opinion, claimant would benefit from and should be provided with chronic pain management.

Dr. Murati reviewed the task list of Doug Lindahl and found claimant had lost the ability to perform 14 previous tasks for a 100 percent task loss. This opinion was based on his conclusion claimant could not perform a single task on the list safely because of either the weight involved or the required frequent reaching. Dr. Murati testified the two restrictions for the neck and back would not keep claimant from performing any of the tasks on the task list and it was the shoulder restrictions that left claimant with a 100 percent task loss.⁵

Dr. Murati confirmed claimant had not received any treatment for the neck or upper back. Since he didn't expect claimant to have any treatment for these areas he rated them. Dr. Murati testified that claimant's neck and back pain developed over time. He stated that usually the pain starts and over time becomes permanent and constant in quality and severity until it becomes chronic. He could not say the exact date and time claimant's neck and back pain started. He testified the neck and back pain were the result of the strain on the shoulder muscles.

Claimant met with board certified family practice physician David Hufford, M.D., on January 22, 2013, for a court-ordered Independent Medical Evaluation (IME) for the left shoulder. Claimant presented with weakness and limited range of motion in the left shoulder post replacement surgery in July 2012. Dr. Hufford wrote claimant also complained of neck pain throughout the course of her treatment for the left shoulder, but denied any significant paresthesias or other upper extremity symptoms distal to the shoulder. Dr. Hufford wrote claimant continued with her physical therapy exercises. She had a remote history of a clavicle fracture of the left shoulder, but with no subsequent symptoms or limitations in her activities. Dr. Hufford found claimant's general health to be good.

Dr. Hufford's examination of the cervical spine revealed no direct vertebral tenderness. There was no tenderness in the cervical paraspinal musculature. There was

⁵ Murati Depo. at 22-23.

some tenderness across the upper scapular elevators in the shoulder without trigger points or guarding. Dr. Hufford noted mild tenderness at the acromioclavicular joint and tenderness over the deltoid above the rotator cuff.

There was no evidence of significant pathologic findings in the left upper extremity, no tenderness about the elbow and Tinel's testing at the elbow was negative. There was no evidence of swelling, tenderness or crepitus in the left forearm. There was no evidence of swelling or localized tenderness in the left wrist and hand and Tinel's at the wrist was negative. There were no nodules or triggering of any finger on the left hand. There was no thenar or hypothenar atrophy.

Dr. Hufford opined claimant had a work-related traction injury to the left shoulder with rotator cuff tear and aggravation of degenerative osteoarthritis leading to a total shoulder replacement. Dr. Hufford determined claimant was at maximum medical improvement for her injuries which he limited to the left shoulder, but not the cervical spine. The mechanism of injury involved direct hyperextension of the shoulder with some torsion and should not have injured the cervical spine. It is Dr. Hufford's opinion that claimant "has residual pain throughout the scapular elevators which are extrinsic muscles of the shoulder involved in supporting its function due to her limited range of motion following the rotator cuff repair and total shoulder replacement."⁶ He noted claimant had no other symptoms referable to the cervical spine except for possibly pain which he believes originated from the shoulder.

Dr. Hufford assigned claimant a 30 percent permanent partial impairment to the left upper extremity for arthroplasty and an 11 percent permanent impairment to the left upper extremity for diminished range of motion due to the rotator cuff injury. Combined, these impairments equal a 38 percent left upper extremity impairment at the level of the shoulder. His ratings were based on the *AMA Guides*, 4th edition. He did not recommend apportionment for the underlying glenohumeral arthritis which contributed to the need for the total shoulder replacement.

Dr. Hufford recommended claimant not use her left arm above shoulder level, no lifting greater than 10 pounds with the left arm and no greater than 20 pounds for a two-handed lift. On May 30, 2013, he wrote that his opinion remains there is no cervical spine component to claimant's injury, nor any evidence of impairment. He again opined any pain claimant experiences in the cervical spine is referred from the left shoulder. He noted the amount of pain claimant is experiencing in the cervical spine does not constitute a separate impairment based on the entirely subjective symptoms of pain without a basis for documented tissue injury from the mechanism of injury nor any radiologic studies that have been done.

⁶ Hufford Depo., Ex. 2 at 2 (Dr. Hufford's January 22, 2013, report).

Claimant met with physical medicine and rehabilitation specialist David Harris, D.O., for a court-ordered IME, on February 10, 2014. The purpose of the IME was to provide an opinion and recommendation for treatment of the left shoulder, if any, and for pain management. Claimant denied any prior injuries that reproduced symptoms similar to those which she is currently experiencing. Claimant's history to Dr. Harris included the incident with the machine pulling her left arm. Claimant reported immediate pain in her left shoulder, with midline neck pain beginning a few days to a week after the July 18, 2011, accident.

Claimant reported current pain in her left shoulder and neck. She reported this pain was different from the what she experienced at the time of the initial injury. Her current pain radiates down into her hand and into all five of her fingers along the volar forearm. She describes the pain as sharp, stabbing, dull, numb and tingling depending on the situation. At the time of this visit her pain was primarily sharp and burning. Claimant reported the pain is worse with activity, but she also has pain when she isn't doing anything. Her pain is improved with the proper medication. Claimant reported the pain was at a 9 out of 10 at this visit and reported it has averaged from 7 to 10 out of 10 over the past month before this visit. She reported difficulty showering and performing some household tasks. Dr. Harris noted claimant did not demonstrate mannerisms consistent with her stated pain level of 9 out of 10.

Dr. Harris noted claimant has not worked since June 12, 2012, with claimant's employment being terminated in November 2012 because respondent was unable to accommodate her restrictions. Claimant has not sought work because of her neck and shoulder pain and work restrictions.

During the examination, claimant reported night pain and night sweats from her pain medication, some blurred vision, headaches, chest pain, joint pain, stiffness and numbness and pruritus in the skin and some depression. On a pain diagram, claimant drew her pain from the cervicospinal junction on the anterior facing down the middle of the shoulder and down the arm over the anterior aspect of the arm towards, but not touching the medial epicondyle and down the middle of the volar wrist to the end of the palm at the middle. On the posterior, from the cervicospinal junction and vertically from approximately T1 or T2 up to the inferior occipital ridge.

Claimant had an MRI on July 28, 2011, which displayed: 1) a large horizontal tear extending through the entire length of the supraspinatus tendon and extending to the humeral articular surface; 2) no full thickness or complete tear or retraction; 3) acromioclavicular arthropathy was identified; 4) a joint effusion with fluid extending from the subacromial interval into the subacromial bursa; 5) and a small osteophyte in the inferior and medial humeral head, which could not exclude injury to the inferior labrum.

Dr. Harris noted claimant met with Zhengyu Hu, M.D., for pain management from August 14, 2012, through April 30, 2013. Dr. Hu noted claimant was on significant

narcotics and tried to wean her down. As claimant was being weaned she complained of nausea, headaches and inefficiency of the replacement medication. Claimant's prescription for Percocet was restored. When it was discovered claimant was taking extra Percocet she was taken off the medication and a variety of other combinations were tried, but nothing helped with her pain.

Dr. Harris examined claimant and assessed the following: status post work injury on July 18, 2011; chronic left shoulder and neck pain; status post left arthroscopic shoulder surgery with decompressive acromioplasty and rotator cuff repair on August 19, 2011; status post left total shoulder arthroplasty on June 12, 2012; chronic pain syndrome with history of poor control, and some evidence of symptom magnification with insincerity of effort as noted during the examination by Dr. Harris.

Dr. Harris agreed the narcotics should be minimized or eliminated. He noted most of the treatment options have been exhausted and a trial of a TENS unit should be considered, opining a TENS unit could provide mild relief of claimant's symptoms and would be a non-chemical source of pain relief. Dr. Harris indicated claimant may be more interested in seeking narcotics by finding reasons for them to not work than she was in improving. He recommended a home exercise program and a cardiopulmonary training exercise program 5 days a week for 30 minutes.

Claimant met with Doug Lindahl on May 31, 2013, for a vocational assessment. Mr. Lindahl identified 14 tasks performed by claimant during the five years prior to the injury. Mr. Lindahl testified that because claimant had no transferrable skills, there were no jobs she could perform from her past work based on her restrictions, so he looked for any job either unskilled or very low semi-skilled she could pick up quickly and learn. He went on to find claimant could, within her restrictions, work in the following jobs on a part-time basis: part-time housekeeper in Manhattan at the Park Wood Inn; part-time cashier at Paradise Donuts; part-time housekeeper at the Junction City Motel 6, and team worker at Taco Bell in Junction City. Ultimately, he felt the job as a part-time housekeeper at the Junction City Motel 6 would be the most appropriate for claimant's earning capacity at the time. He saw no reason claimant would not be able to get a full-time job at some point in the future. He opined claimant's earning capacity at the time was \$199.38 per week. He did not have information on claimant's average weekly wage to figure wage loss.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 2011 Supp. 44-501b(b)(c) states:

(b) If in any employment to which the workers compensation act applies, an employee suffers personal injury by accident, repetitive trauma or occupational disease arising out of and in the course of employment, the employer shall be liable to pay compensation to the employee in accordance with and subject to the provisions of the workers compensation act.

(c) The burden of proof shall be on the claimant to establish the claimant's right to an award of compensation and to prove the various conditions on which the claimant's right depends. In determining whether the claimant has satisfied this burden of proof, the trier of fact shall consider the whole record.

K.S.A. 2011 Supp. 44-508(d) states:

(d) "Accident" means an undesigned, sudden and unexpected traumatic event, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. An accident shall be identifiable by time and place of occurrence, produce at the time symptoms of an injury, and occur during a single work shift. The accident must be the prevailing factor in causing the injury. "Accident" shall in no case be construed to include repetitive trauma in any form.

K.S.A. 2011 Supp. 44-508(f) states in part:

(f) (1) "Personal injury" and "injury" mean any lesion or change in the physical structure of the body, causing damage or harm thereto. Personal injury or injury may occur only by accident, repetitive trauma or occupational disease as those terms are defined.

(2) An injury is compensable only if it arises out of and in the course of employment. An injury is not compensable because work was a triggering or precipitating factor. An injury is not compensable solely because it aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic.

...
(B) An injury by accident shall be deemed to arise out of employment only if:
(i) There is a causal connection between the conditions under which the work is required to be performed and the resulting accident; and
(ii) the accident is the prevailing factor causing the injury, medical condition, and resulting disability or impairment.

Claimant contends she suffered injuries to her left upper extremity and neck during or as a result of the accident on July 18, 2011. However, claimant was treated by Dr. Jones for nearly two years without mentioning the neck complaints. His records contain no reference to claimant's alleged neck pain. Dr. Jones testified he would have noted the neck complaints had they been mentioned.

While claimant mentioned neck complaints to Dr. Hufford, he was unable to find significant pathologic findings in the neck that would justify a permanent impairment. He assessed only functional impairments to the left shoulder for the arthroplasty and diminished range of motion.

While Dr. Harris noted neck complaints, his main concern appeared to be claimant's possible dependence on narcotic medications. It was only Dr. Murati who identified neck complaints attributable to the accident on July 18, 2011.

The ALJ found the most credible evidence in this matter to be that from Dr. Jones. The Board agrees with this finding. Claimant's permanent impairment in this matter is limited to the left upper extremity at the shoulder.

K.S.A. 2011 Supp. 44-508(u) states:

(u) "Functional impairment" means the extent, expressed as a percentage, of the loss of a portion of the total physiological capabilities of the human body as established by competent medical evidence and based on the fourth edition of the American medical association guides to the evaluation of impairment, if the impairment is contained therein.

The ALJ noted the three opinions offered regarding claimant's permanent impairment of function to the left shoulder. In analyzing the opinions of Dr. Jones, Dr. Murati and Dr. Hufford the ALJ found Dr. Hufford's to be the most credible as it considers not only the left shoulder replacement but also the residual problems to the shoulder. The award of a 38 percent functional impairment to the left upper extremity at the level of the shoulder is affirmed.

K.S.A. 2011 Supp. 44-510h(a) states:

(a) It shall be the duty of the employer to provide the services of a health care provider, and such medical, surgical and hospital treatment, including nursing, medicines, medical and surgical supplies, ambulance, crutches, apparatus and transportation to and from the home of the injured employee to a place outside the community in which such employee resides, and within such community if the director, in the director's discretion, so orders, including transportation expenses computed in accordance with subsection (a) of K.S.A. 44-515, and amendments thereto, as may be reasonably necessary to cure and relieve the employee from the effects of the injury.

The Award grants claimant future medical treatment for pain management with the treatment limited to the left upper extremity. Any additional future medical treatment will be considered upon proper application. The rulings by the ALJ on these issues is affirmed.

CONCLUSIONS

Having reviewed the entire evidentiary file contained herein, the Board finds the Award of the ALJ should be affirmed. Claimant's injuries resulting from the July 18, 2011, accident are limited to a 38 percent functional impairment to the left upper extremity at the shoulder. Claimant has failed to prove impairment apart from her left shoulder as a result of her accident.

AWARD

WHEREFORE, it is the finding, decision and order of the Board that the Award of Administrative Law Judge Rebecca Sanders dated September 8, 2014, is affirmed.

IT IS SO ORDERED.

Dated this _____ day of February, 2015.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

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